

SIGNIFICANT OTHERS FORM

PLEASE MAKE A FRIEND OR YOUR SPOUSE FILL OUT THIS FORM

This person can be anyone close to you - who knows you well.

If the question is directed towards the patient, you may answer according to your observations of the patient.

Please modify this form directly (PDF)

Do not print this document

Please send it back to us in the same format (PDF)

For more information, visit www.excellemd.com/en/ADHD.

If you have any questions, contact us at 450-735-8111 (1-844-735-8111)

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ADULT ADHD SELF-REPORT SCALE (ASRS-V1.1) SYMPTOM CHECKLIST

Patient: _____ Date Completed: _____

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during your appointment.	Never	Rarely	Sometimes	Often	Very often
PART A					
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
How often do you have difficulty getting things in order when you have to do a task that requires organization?					
How often do you have problems remembering appointments or obligations?					
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
How often do you feel overly active and compelled to do things, like you were driven by a motor?					
PART B					
How often do you make careless mistakes when you have to work on a boring or difficult project?					
How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
How often do you misplace or have difficulty finding things at home or at work?					
How often are you distracted by activity or noise around you?					
How often do you leave your seat in meetings or in other situations in which you are expected to stay seated?					
How often do you feel restless or fidgety?					
How often do you have difficulty unwinding and relaxing when you have time to yourself?					
How often do you find yourself talking too much when you are in social situations?					
When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish it themselves?					
How often do you have difficulty waiting your turn in situations when turn taking is required?					
How often do you interrupt others when they are busy?					

WEISS FUNCTIONAL IMPAIRMENT RATING SCALE – SELF REPORT (WFIRS-S)

Patient Name: _____ Date: _____ Date of Birth: _____

Work: _____ Full Time ____ Part Time ____ Other: _____

School: _____ Full Time ____ Part Time ____

Circle the number for the rating that best describes how your emotional or behavioural problems have affected each item in the last month.

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
A	FAMILY					
1	Having problems with family					
2	Having problems with spouse/partner					
3	Relying on others to do things for you					
4	Causing fighting in the family					
5	Makes it hard for the family to have fun together					
6	Problems taking care of your family					
7	Problems balancing your needs against those of your family					
8	Problems losing control with family					
B	WORK					
1	Problems performing required duties					
2	Problems with getting your work done efficiently					
3	Problems with your supervisor					
4	Problems keeping a job					
5	Getting fired from work					
6	Problems working in a team					
7	Problems with your attendance					
8	Problems with being late					
9	Problems taking on new tasks					
10	Problems working to your potential					
11	Poor performance evaluations					
C	SCHOOL					
1	Problems taking notes					
2	Problems completing assignments					
3	Problems getting your work done efficiently					
4	Problems with teachers					
5	Problems with school administrators					
6	Problems meeting minimum requirements to stay in school					
7	Problems with attendance					
8	Problems with being late					
9	Problems with working to your potential					
10	Problems with inconsistent grades					
D	LIFE SKILLS					
1	Excessive or inappropriate use of internet, video games or TV					
2	Problems keeping an acceptable appearance					
3	Problems getting ready to leave the house					
4	Problems getting to bed					
5	Problems with nutrition					
6	Problems with sex					

		Never or not at all	Sometimes or somewhat	Often or much	Very often or very much	n/a
7	Problems with sleeping					
8	Getting hurt or injured					
9	Avoiding exercise					
10	Problems keeping regular appointments with doctor/dentist					
11	Problems keeping up with household chores					
12	Problems managing money					
E	SELF-CONCEPT					
1	Feeling bad about yourself					
2	Feeling frustrated with yourself					
3	Feeling discouraged					
4	Not feeling happy with your life					
5	Feeling incompetent					
F	SOCIAL					
1	Getting into arguments					
2	Trouble cooperating					
3	Trouble getting along with people					
4	Problems having fun with other people					
5	Problems participating in hobbies					
6	Problems making friends					
7	Problems keeping friends					
8	Saying inappropriate things					
9	Complaints from neighbours					
G	RISK					
1	Aggressive driving					
2	Doing other things while driving					
3	Road rage					
4	Breaking or damaging things					
5	Doing things that are illegal					
6	Being involved with the police					
7	Smoking cigarettes					
8	Smoking marijuana					
9	Drinking alcohol					
10	Taking "street" drugs					
11	Sex without protection (birth control, condom)					
12	Sexually inappropriate behaviour					
13	Being physically aggressive					
14	Being verbally aggressive					

Number of Items Scored '2' or '3'

A	Family		
B	Work		
C	School		
D	Life Skills		
E	Self-concept		
F	Social		
G	Risk		
	Total		

Total Score

A	Family		
B	Work		
C	School		
D	Life Skills		
E	Self-concept		
F	Social		
G	Risk		
	Total		

Mean Score (N/A items not included in calculation)

A	Family		
B	Work		
C	School		
D	Life Skills		
E	Self-concept		
F	Social		
G	Risk		
	Total		

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WEISS SYMPTOM RECORD II

PATIENT: _____

INFORMANT: _____

This is a problem checklist. Not all the items will be appropriate for you. Please indicate the level of difficulty associated with each item:

- None:** This is not a problem or concern. Any challenges are age-appropriate
- Mild:** Some difficulty (somewhat)
- Moderate:** This is a problem (pretty much)
- Severe:** This is a serious problem (very much)
- NA:** Not applicable. Check this column if the item is not a problem or not relevant to you.

<i>Difficulty with:</i>	<i>None (0)</i>	<i>Mild (1)</i>	<i>Moderate (2)</i>	<i>Severe (3)</i>	<i>N/A</i>
ATTENTION: Mean Score _____					
Attention to details or makes careless mistakes					
Holding attention or remaining focused					
Listening or mind seems elsewhere					
Instructions or finishing work					
Organizing (e.g. time, messy, deadlines)					
Avoids or dislikes activities requiring effort					
Loses or misplaces things					
Easily distracted					
Forgetful (e.g. chores, bills, appointments)					
HYPERACTIVITY AND IMPULSIVITY: Mean Score _____					
Fidgets or squirms					
Trouble staying seated					
Runs about or feels restless inside					
Loud or difficulty being quiet					
Often on the go					
Talks too much					
Blurts out comments					
Dislikes waiting (e.g. taking turns or in line)					
Interrupts or intrudes on others (e.g. butting in)					
OPPOSITIONAL: Mean Score _____					
Loses temper					
Easily annoyed					
Angry and resentful					
Argues					
Defiant					
Deliberately annoys other people					
Blames other people rather than themselves					
Spiteful					